Westcoast Family Centres

Family T.I.E.S. Program
COUNSELING INTAKE QUESTIONNAIRE

Name_____Age_____ DOB_____

Full Address_____

_____

Preferred Phone_____ Alternate Phone_____

E-mail_____

Marital Status _____ Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____

If Client is a Minor, Name of Responsible Adult _____

Name of Closest Friend/Relative_____ Relationship to you_____

Phone _____Full Address _____

Physical History

There are times when prior medical and psychological records may be requested with your written permission. Please make sure that all information given below is correct.

General Health_____

Last Medical Examination_____Are you now under a doctor's care?_____If yes, name of

doctor_____ Reason for doctor's care_____

Are you taking any medication?_____If yes, what kind?_____

Reason for medication_____Last medical examination_____

Have you ever been hospitalized for a physical illness?____Describe_____

_____

Have you ever been hospitalized for a mental illness?____Describe_____

_____

Any recent major illnesses or surgeries?_____

All information is requested for the purpose of serving your personal needs. Records are kept confidential.

Any recurrent or chronic conditions?_____

Do you smoke:_____Do you take drugs?_____If yes, what kind & how often?_____

Do you drink?_____How much & how often?_____

Any Previous Therapy/Counseling? _____

When and Number of Sessions: _____

Type of Therapy/Counseling: _____

Work History

Occupation_____ How long?_____

If presently unemployed, describe the situation_____

_____

Hobbies/Avocations_____

Family Systems Information

Where born_____How long there_____Ethnic ID_____

Parents: Father alive_____Where residing_____Relationship_____

Mother alive_____Where residing_____Relationship_____

Your Children:#1 M F Age_____ #2 M F Age_____ #3 M F Age_____#4 M F Age_____#5 M F Age_____

Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age_____

Family Alcoholism or Domestic Violence?_____ Sexual Addictions or Abuse?_____

Parents divorced?_____If yes, what year_____Your age at the time_____

If deceased, what year?_____Your age at the time_____Cause of death_____

Any step-parents?_____If yes, describe when and your relationship with them_____

_____

If reared by someone other than your birth parents, describe the situation in some detail_____

_____

Spiritual History

Religious upbringing_____Present Affiliation_____

Is this an important part of your life_____Whywhy not_____

Emotional Status

Are you currently experiencing strong emotions? ____If yes, describe_____

_____

Did you have what you would consider to be childhood or other traumas?_____If yes, describe_____

_____

Have you had any thoughts of suicide? ____If so, when_____Do you have any thoughts now?_____

Present Situation

Please state why you decided to come for counseling/therapy_____

_____

What is the nature of your situation?_____

_____

What would you like to experience that is different from what you are experiencing now?_____

_____

How long has this been a problem for you?_____

_____

Please state what you would like to work on in therapy, or what do you hope to achieve with therapy?

_____

_____

Tell anything else in the space below that you think would be helpful for your therapist to know.